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*Please complete the* ***FRONT PAGE ONLY*** *and return to the front desk.* **Date:**

 **Dr.** **Mr.** **Mrs.** **Ms.** **Miss.**

**Last Name:**  **Male** **Female**

**First Name:**

 **Date of Birth:** **Age**

**Address:** Day/month/year

 **OHIP Number:** \_\_\_\_

**City:** **Referred By:**

**Postal Code:** **Family Dr :**

**Home:** ( ) **Family Dr Tel:**

**Work:** ( ) **Family Dr Fax:**

**Cell #:** ( ) **Patients** **Email:**

*Confidential Medical Information*

**Do you have?** **YES NO**

High Blood Pressure **Do you drive?**

Heart Disease Yes No

Diabetes

Cataracts **Do you wear contact lenses?**

Glaucoma Yes No

Macular Degeneration

Retinal Detachments **Do you have allergies to medications?**

AIDS/HIV Yes No

Hepatitis if so

Asthma/ COPD

Herpes Simplex/ Zoster **Have you had eye surgery or laser?**

Rheumatoid Arthritis Yes No

Lupus/ Autoimmune Disease What type?:

High Cholesterol When?:

Other:

**Do you have a family history of? YES NO Which Member (s)?**

Glaucoma

Cataracts

Macular Degeneration

Retinal Detachment

**Would you like more information on?**

Botox and/or Juvederm Cosmetic

Laser Eye Vision Correction

Contact lenses

**\*\* OFFICE USE ONLY\*\***

**CHIEF COMPLAINT:**

**HISTORY OF P.I:**

**PAST OCULAR HX:**

**SYSTEMIC MEDICATIONS OCULAR MEDICATIONS**

**VISUAL ACUITY**

*DISTANCE* *NEAR*

OD 20/ OS 20/ OD OS

cc cc

sc sc

*PINHOLE* *OCULAR MOTILITY* Normal Defect

OD 20/ OS 20/

*PUPILS*  PERLA RAPD

**CURRENT GLASSES** **2ND PAIR**

OD ADD OD ADD

OS ADD OS ADD

**AUTO REFRACTION** **IOP**

OD mmHg @ **am / pm**

OS mmHg

 **DT M1% Cyclo Pilo Alph P Mydf Alcaine** **CT**  / µ

@ **am / pm** /µ